4-7-1976

# Mattie S. Henry v. Blue Cross Hospital Plan, Inc.

Appellee's Brief 1975-SC-1142

# APPELLEE'S BRIEF

556

# SUPREME COURT OF KENTUCKY

**No. 75-1142**

**MATTIE S. HENRY,** - - - - - - **Appellant,**

*v.*

**BLUE CROSS HOSPITAL PLAN, INC.,** - **Appellee.**

ON APPEAL FROM SUMMARY JUDGMENT
ENTERED BY THE DAVIESS CIRCUIT COURT
HONORABLE ROBERT M. SHORT, JUDGE

## BRIEF OF BLUE CROSS HOSPITAL PLAN, INC.



JOSEPH M. DAY
RONALD L. GAFFNEY
BARNETT & ALAGIA
1700 Kentucky Home Life Building
Louisville, Kentucky 40202
*Counsel for Blue Cross Hospital Plan, Inc.*

It is hereby certified that this brief was served upon Jerry W. Nall, Counsel for the Appellant, Suite 12-16 Odd Fellows Building, Owensboro, Kentucky 42301, and the Honorable Robert M. Short, Judge of the Daviess Circuit Court, Daviess County Courthouse, Owensboro, Kentucky 42301, by mailing copies thereof, postage prepaid, pursuant to RAP 1.250, on this 7th day of April, 1976.

Ronald L. Gaffney
*Counsel for Blue Cross Hospital Plan, Inc.*

WESTERFIELD-BONTE CO., 619 W. KENTUCKY—P.O. BOX 3251, LOUISVILLE, KY.

## TABLE OF CONTENTS AND AUTHORITIES

## STATEMENT OF THE QUESTIONS PRESENTED

I.

Is a Blue Cross membership certificate clause, which specifically excludes hospitalization benefits when coverage is available under the laws of the United States, ambiguous, unreasonable or against public policy?

II.

Did the trial court err in granting summary judgment?

# SUPREME COURT OF KENTUCKY

No. 75-1142

---

MATTIE S. HENRY, - - - - *Appellant,*

*v.*

BLUE CROSS HOSPITAL PLAN, INC., - *Appellee.*

---

ON APPEAL FROM SUMMARY JUDGMENT
ENTERED BY THE DAVIESS CIRCUIT COURT
HONORABLE ROBERT M. SHORT, JUDGE

---

## BRIEF OF BLUE CROSS HOSPITAL PLAN, INC.

---

### COUNTERSTATEMENT OF THE CASE

#### Nature of the Proceeding

This proceeding is an appeal from a summary judgment of the Daviess Circuit Court entered on October 2, 1975, whereby the Appellee, Blue Cross Hospital Plan, Inc. (hereafter called "Blue Cross"), was granted judgment against the Appellant, Mattie S. Henry (hereafter called "Plaintiff").

On September 4, 1974, the Plaintiff filed a complaint against Blue Cross, requesting judgment in the amount of $9,944.75 because of the alleged "willful and wanton breach and refusal" of Blue Cross to pro-

vide hospitalization benefits for the Plaintiff in the amount of $4,944.75 (Transcript, pp. 1-4). Blue Cross answered the complaint by stating that the Plaintiff had already received $1,598.95 of the total amount requested from the Medicare Division of the Department of Health, Education & Welfare, Social Security Administration, and $72.00 from Blue Cross as supplemental coverage (Transcript, pp. 7-8 & 25). Blue Cross denied liability for the remaining amount to the extent that benefits for the hospitalization services were available under the Medicare laws of the United States (Transcript, pp. 9-10 & 25-26).

On October 2, 1975, the Daviess Circuit Court found that there was no genuine issue of any material fact and that Blue Cross was entitled to summary judgment as a matter of law because the Plaintiff's certificate of membership provided that Blue Cross is required to provide benefits to the Plaintiff only to the extent that benefits are not available under the Medicare laws of the United States (Transcript, p. 94). This appeal followed.

**Statement of Facts**

The Plaintiff became a member of Blue Cross, a nonprofit hospital service corporation, on an individual direct pay basis on May 15, 1969 (Transcript, pp. 2 & 7). Pursuant to this membership, she was entitled to hospitalization benefits as provided in her certificate of membership (Transcript, p. 7).

In 1970, the Plaintiff was involved in an accident which rendered her totally and permanently disabled

(Transcript, pp. 56 & 80). In 1972, Subchapter XVIII, 42 U.S.C. § 1395, *et seq.*, Health Insurance for Aged and Disabled (hereinafter referred to as "Medicare"), was amended to make persons regardless of age who had received Social Security disability benefits for twenty-four (24) consecutive months automatically eligible for Medicare hospitalization and medical benefits. Due to her disability, the Plaintiff became automatically eligible for Medicare hospitalization benefits in July, 1973 (Transcript, pp. 38, 40 & 47; Letter of Joseph D. Noble, Social Security District Manager).

Medicare is a federal health insurance program operated by the Social Security Administration. Medicare has two parts. One part is hospital insurance. The other is medical insurance. Hospital insurance is available free of charge for eligible persons. Medical insurance is available for qualifying persons for a small monthly premium. *See* Department of Health, Education and Welfare, "Your Medicare Handbook," DHEW Publication No. (SSA) 75-10050 (March, 1975).

Since Medicare, like most insurance, does not cover all hospital services, persons covered by Medicare frequently carry supplemental insurance, usually at a reduced rate. Upon receiving information that the Plaintiff was eligible for Medicare benefits, Blue Cross notified the Plaintiff that she no longer needed full coverage and advised her that supplemental coverage, at a reduced premium, was available to her and more feasible for her (Transcript, pp. 91 & 92). Under this supplemental program, the Plaintiff could obtain any

hospitalization services possible, including private or semi-private rooms. Any benefits not provided by Medicare would be provided by Blue Cross as allowed by the Plaintiff's membership certificate. This was precisely the course followed by Blue Cross on Plaintiff's initial hospitalization claim. The Plaintiff ignored the advice of Blue Cross.

Subsequently and intermittently, during the period of August 8, 1973 through April 4, 1974, the Plaintiff was hospitalized on several occasions (Transcript, pp. 2 & 25). She was fully eligible for Medicare benefits during the entire period (Transcript, pp. 38, 47, 73 & 77). Although a claim was filed with and paid by Medicare for Plaintiff's first hospitalization (supplemental expenses being paid by Blue Cross), the Plaintiff thereafter filed no further hospitalization claims with Medicare (Transcript, pp. 25, 39-40 & 81).

Instead, the Plaintiff filed claims, including a claim for the initial hospitalization previously paid by Medicare, with Blue Cross. Blue Cross denied coverage to the Plaintiff because the benefits requested were specifically excluded by the terms of her certificate of membership (Transcript, pp. 39 & 40).

The Plaintiff's certificate of membership with Blue Cross specifically provides:

> Blue Cross shall not be required under this Agreement to provide . . . services or to pay indemnity for . . . treatment for which indemnification or hospital care is available under the laws of the United States . . . (Transcript, pp. 25 & 30).

This exclusionary clause has been an included clause in every Blue Cross membership certificate since, at least, 1958.

## ARGUMENT

### I.

**A Blue Cross Membership Certificate Clause, Which Specifically Excludes Hospitalization Benefits When Coverage Is Available Under the Laws of the United States Is Not Ambiguous, Unreasonable or Against Public Policy.**

As a member of Blue Cross, the Plaintiff is entitled to all the benefits covered by her certificate of membership. Simultaneously, Plaintiff is subject to all the limitations, conditions and exclusions contained in the membership certificate.

The Plaintiff's certificate of membership provides that Blue Cross shall not be required to provide services or to pay indemnity for treatment for which indemnification or hospital care is available under the laws of the United States or any state or political subdivision thereof (Transcript, p. 30). It is the effect of this exclusionary clause on Blue Cross hospitalization benefits where Medicare coverage is also available which is at issue in this case.

It is uncontradicted and unrefuted that Plaintiff had Medicare coverage available to her at all times at issue in this case (Transcript, pp. 38, 47, 73 & 77). Medicare benefits were actually received for one of Plaintiff's hospitalizations (Transcript, pp. 25, 39 & 81).

Similarly, it is uncontradicted that Medicare is a system of care or indemnity for hospital care and/or treatment available pursuant to the laws of the United States. *See* 42 U.S.C. § 1395 (Supp. 1975). Through the exclusionary provision, Blue Cross gives notice to subscribers that it will deny hospitalization benefits to subscribers to the extent coverage is available under Medicare and other similar governmental insurance programs. Furthermore, Blue Cross specifically advised the Plaintiff that it would not duplicate payments available under Medicare (Transcript, p. 92).

### A. THE EXCLUSIONARY CLAUSE IS CLEAR AND UNAMBIGUOUS.

Plaintiff claims that the exclusionary provision at issue herein is ambiguous and, therefore, should not be applied to Plaintiff. A term is ambiguous when the meaning is "obscure" or is "susceptible of two or more interpretations." *See Gibson v. Sellars,* Ky., 252 S.W.2d 911, 913 (1952). The language used in the exclusionary clause at issue in this case is plain, simple and subject to only one interpretation: if coverage for hospital care is available under a state or federal law, Blue Cross coverage is unavailable until the state or federal coverage is exhausted.

It is universally accepted that the parties to a contract are bound by its clear and unambiguous terms. *See, e.g., American National Bank & Trust Co. v. Hartford Accident & Indemnity Co.,* 442 F.2d 995 (6th Cir. 1971); *Pennsylvania Casualty Co. v. Elkins,* 70 F. Supp. 155 (E.D. Ky. 1947); *Weaver v. National Fidelity Ins. Co.,* Ky., 377 S.W.2d 73 (1963); *Bonnie*

*v. Maryland Casualty Co.,* 280 Ky. 568, 133 S.W.2d 904 (1939); *Jefferson v. New York Life Ins. Co.,* 151 Ky. 609, 151 S.W. 780 (1913).

A mere allegation of ambiguity does not make lucid language ambiguous, nor does the rule of liberal construction permit a court to disregard the clear language of a contract. For example, in *Brotherhood of Railroad Trainmen v. Wilkins,* 257 Ky. 331, 78 S.W.2d 6 (1935), an insured who had lost several fingers in an accident argued that an insurance contract which limited coverage to amputations of the "entire hand at or above the wrist" was ambiguous and did not exclude coverage for his injury. The Court, in directing a verdict for the insurer, stated the ground rules in construing contracts:

> An insurance contract, like any other contract, fixes, defines, and measures the rights of the parties thereto. Such contracts require a reasonable interpretation as a whole so as to effectually carry out the intention of the parties within the clear meaning of the terms employed. If the terms employed in a policy contract are so ambiguous or uncertain as to admit of two interpretations, it will be construed strictly against the insurer and liberally in favor of the insured and that interpretation adopted which will protect the former in preference to that which will defeat his claim. However, the foregoing rules do not authorize courts to disregard plain, unambiguous, and easily understood terms or provisions of a contract exempting the insurer from liability under certain conditions. Courts cannot under the rule of liberal construction make new or different contracts enlarging or diminishing the rights and liabilities

> of the parties where the meaning of the language employed to define or limit such rights or liabilities is obvious. *Id.* at 8 (citations omitted).

As in *Brotherhood of Railroad Trainmen v. Wilkins,* the language used in the exclusionary clause at issue herein is manifestly clear. To adopt the position urged by Plaintiff would ignore the clear and unambiguous terms of the certificate of membership and result in a contract different from that made by the parties. The trial court, therefore, did not err in enforcing the contract as written.

Plaintiff argues that the exclusionary clause at issue in this case should not apply to Medicare benefits because the exclusion pre-dates the existence of Medicare. *See* Appellant's Brief at 7. As noted previously, this exclusionary clause has been included in Blue Cross contracts since 1958. Medicare was created in 1965. Hospitalization benefits were available to disabled persons under the 1965 Act. Plaintiff's current coverage became effective in 1969. Thus, the law to which this extension relates was in existence prior to Plaintiff's current coverage (Transcript, p. 52). However, even if the law had not preceded the exclusion, the contract is to speak for itself and its terms are to be the best evidence of the intent of the parties. In Kentucky, therefore, the intent and meaning of the contract is to be determined by the language of the instrument itself. As noted in *Gibson v. Sellars, supra* at 913, a case in which an argument similar to Plaintiff's was rejected:

> An extension of the rule (that a contract speaks for itself) would result in chaos and confusion, and it

> would be impossible to determine the rights of the parties to a contract without viewing all the circumstances surrounding the execution of the document in question.
>
> In determining the intention of the parties to the contract before us, we are, therefore, restricted to the instrument itself and we have no right to vary or alter the meaning of the words . . . .

The exclusion herein clearly denies coverage where coverage is available under the laws of the United States. Medicare undeniably qualifies as such coverage, and it is available to Plaintiff. Blue Cross should not be denied the clearly intended effect of the exclusion.

### B. THE EXCLUSION IS NOT UNREASONABLE, UNCONSCIONABLE OR AGAINST PUBLIC POLICY.

Plaintiff also urges that the exclusionary clause is inapplicable to her because it is unreasonable, unconscionable and violative of public policy. *See* Appellant's Brief at 11. No particular example of how this exclusionary provision violates these considerations is provided, however, because none exist.

Similar exclusionary provisions have long been upheld by numerous courts. For instance, it is commonly accepted that contractual provisions excluding recovery in those instances in which an insured is entitled to compensation for his expenses from some other source are valid. *See generally Couch on Insurance 2d,* § 41:865 (1973). Surely no one would argue the validity of an "other insurance" exclusionary provision on the grounds that on the effective date of the coverage

the insured did not own "other insurance" and, therefore, the clause is inapplicable because it predates the availability of the "other insurance." Several courts have upheld provisions excluding coverage to the extent workmen's compensation insurance benefits or other state insurance programs are available to the insured. *See, e.g., Williams v. Insurance Co. of North America,* 434 P.2d 395 (Mont. 1970); *Rabin v. Empire Mutual Ins. Co.,* 290 N.Y.S.2d 241, *aff'd* 291 N.Y.S.2d 906, *aff'd* 299 N.Y.S.2d 1 (N.Y. 1969); *Booth v. Seaboard Fire & Marine Ins. Co.,* 285 F. Supp. 920 (D.C. Neb. 1968); *Kowick v. Hospital Service Corp.,* 139 N.E.2d 619 (Ill.App. 1956). Such programs are clearly analogous to Medicare in that they involve coverage made available under state or federal laws.

Furthermore, in *Moeller v. Associated Hospital Service,* 106 N.E.2d 16 (N.Y. 1952), an exclusionary provision almost identical to the one at issue in this case was challenged as being unreasonable. It excluded claims for coverage where:

> [H]ospital service [is] provided for under any Compensation Law, or other law enacted by the Legislature of any State or the Congress of the United States.

The court held that the clause was not violative of public policy and that the claimant could not recover under any reasonable or proper construction of the exclusionary provision because compensation benefits were available to him.

The exclusionary provision in the case at bar violates no law, and courts should be adverse to holding con-

tracts unenforceable on grounds of public policy unless illegality is clear. *See Hennis v. B. F. Goodrich Co.,* Ky., 349 S.W.2d 680 (1961). It is clear and unambiguous. It works no unfairness and is not unreasonable. The trial court, therefore, was not only correct in granting Blue Cross a summary judgment, but had a legal duty to do so.

Plaintiff indicates that the fact that she has paid premiums for a period of time is a consideration in determining the validity of the exclusionary provision. *See* Appellant's Brief at 4 & 12. Such a consideration is irrelevant. The validity of an exclusionary provision turns not upon the payment of premiums but upon the clarity and reasonableness of the provision itself. If premium payments determined the effectiveness of contract provisions, exclusionary provisions would be of little or no validity in most cases.

Plaintiff further argues that she did not have knowledge of the exclusionary provision at issue. *See* Appellant's Brief at 3. Plaintiff admits that she is covered by the certificate of membership and the record demonstrates that the exclusionary provision was a part of it. Parties to a contract are charged with actual knowledge of the terms of the contract and are presumed to have knowledge of contractual terms and conditions. *See Clark v. Brewer,* Ky., 329 S.W.2d 384 (1959).

If, as alleged, the Plaintiff had no knowledge of the exclusionary provision at issue herein, the lack of knowledge is attributable to her own actions and

not the actions of Blue Cross. Copies of a subscriber's membership certificate are provided to the subscriber as a matter of course when coverage is granted. Copies of membership certificates are available upon request. Moreover, Blue Cross advised Plaintiff of the Medicare coverage and that it would not duplicate benefits available thereunder (Transcript, p. 92). Plaintiff, therefore, is estopped from denying knowledge.

The Plaintiff also argues that subsequent benefits mistakenly paid by Blue Cross should prevent it from denying liability for the claims. *See* Appellant's Brief at 6. The allegation is irrelevant and significant. Blue Cross has already authorized a suit for refund based upon mistake and administrative error, if necessary (Transcript, p. 71).

As noted by Plaintiff, the same rules applicable to other contracts are applicable to Blue Cross plans. Where the plan is ambiguous, therefore, it is construed in favor of the subscriber. However, as noted in 43 *American Jurisprudence 2d,* Insurance, § 277 (1969):

> [T]he rule of strict construction agains an insurer is applicable to such a [Blue Cross] contract *only* where it is in fact ambiguous [Emphasis added.]

Plaintiff has provided no evidence of ambiguity in her certificate of membership. Similarly, the Plaintiff has not shown any unreasonableness in the exclusionary clause or any public policy considerations which the exclusion violates. Medicare coverage is available to Plaintiff, and Medicare is coverage provided under the laws of the United States. Although Plaintiff errone-

ously claims that the Medicare hospitalization coverage (which is the only coverage at issue) is not free of charge (*see* Appellant's Brief at 4), Medicare hospitalization is clearly available to persons who qualify for Social Security disability benefits at no cost. *See* Department of Health, Education, and Welfare, "Your Medicare Handbook," DHEW (SSA) Publication No. 75-10050 (March, 1975).

Because Medicare benefits are undeniably available to Plaintiff and because the exclusionary provision clearly denies Blue Cross coverage where such governmental benefits are available until they are exhausted, the trial court's decision to grant a summary judgment for Blue Cross was proper and just and should be upheld. Blue Cross is not attempting to cram Medicare down Plaintiff's throat; Blue Cross is merely attempting to preserve the integrity of its contractual arrangement with the Plaintiff.

## II.

### The Trial Court Did Not Err in Granting Summary Judgment.

Although a summary judgment should be granted sparingly, where the legal and factual circumstances are such that resolution by summary judgment is possible and proper, a trial court would be remiss in its duties not to grant such a motion. *See Bennett v. Southern Bell Telephone & Telegraph Co.*, Ky., 407 S.W.2d 403 (1966). Summary judgment is harsh; however, justice demands it in a proper case. In this case, summary judgment was both proper and just.

Plaintiff complains that this action was set for trial on numerous occasions. *See* Appellant's Brief at 12. This, of course, is not germane to the issues before this Court. Moreover, it should be noted that CR 56 of the *Kentucky Rules of Civil Procedure* provides that a party may move for summary judgment at any time. Similarly and significantly, Plaintiff fails to point out that only one continuance was requested by Blue Cross and that it was granted by agreement of the parties (Transcript, p. 20). The other continuances flowed from Plaintiff's own persistent efforts to set the case for trial by jury after the trial court had expressly informed Plaintiff that the case involved a question of law which was to be tried by the Court alone. Additional delays followed from the Plaintiff's incessant attempts to forego a hearing on Blue Cross' motion for summary judgment in favor of a trial (Transcript, pp. 53-55, 82 & 87). Delays caused by such antics, therefore, are merely echoes of Plaintiff's own actions.

Plaintiff urges that the trial court's resolution of this case by summary judgment was improper; however, no germane reasons, in law or in fact, are demonstrated by Plaintiff except statements to the effect that Plaintiff deserved a hearing and an opportunity to present evidence. Disregarded is the fact that Plaintiff was afforded numerous opportunities at hearings on Blue Cross' pending motion for summary judgment to present such evidence as would indicate the existence of a genuine issue of fact (Transcript, pp. 64, 87 & 94). Hearings were scheduled on three different occasions before a hearing was finally held. Moreover, each time the hearings were delayed to provide Plaintiff with an

opportunity to obtain controverting evidence (Transcript, p. 64). Plaintiff failed to produce any controverting evidence; therefore, the trial court not only was not in error in granting the summary judgment but had a legal duty to grant Blue Cross' motion for summary judgment.

Plaintiff acknowledges that this case is essentially one of contract construction. *See* Appellant's Brief at 7. Provided the terms of a contract are clear and unambiguous and not unreasonable, contract construction is essentially a matter of law. *See Gibson v. Sellars, supra.* As noted previously herein, the contract at issue in this case is plain and unambiguous. Moreover, where a contract is plain and unambiguous on its face, the trial court is limited in determining the meaning of the contract to the terms of the contract. *See Gibson v. Sellars, supra.* In contract construction situations, therefore, the credibility of witnesses and the weight of extrinsic evidence are not crucial to the ultimate determination of the case. Consequently, as a case turning on a question of law, the case is precisely of the type where resolution by summary judgment is proper. *See Ogden v. Employers Fire Insurance Co.,* Ky., 503 S.W.2d 727 (1973).

Not only is this case amenable to resolution by summary judgment because of the issue being legal rather than factual, Blue Cross is also entitled to the summary judgment as a matter of law. On innumerable occasions the Kentucky Court of Appeals has followed the general rule that:

> Summary judgment procedure is designed to expedite the disposition of cases. It is the duty of

> the court to render a judgment forthwith if there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Bennett v. Southern Bell Telephone & Telegraph Co., supra* at 404-5.

*In accord, see Sanders v. Stafford,* Ky., 390 S.W.2d 159 (1965); *McDonough v. Schneider,* Ky., 354 S.W.2d 27 (1962); *Chesser v. Louisville Country Club,* Ky., 339 S.W.2d 194 (1960).

The unrefuted and uncontradicted facts in this case are that Plaintiff had coverage available to her under the Medicare Act due to her disability at all times when each and every claim herein at issue was made (Transcript, pp. 73-77). Moreover, the Plaintiff actually made application and received indemnification from Medicare for one of the claims now being asserted against Blue Cross (Transcript, pp. 73 & 76). Plaintiff has never denied that she had Medicare coverage available to her during the period in which each of these claims arose nor has she ever filed counter-proof of that fact. Furthermore, Plaintiff does not refute the fact that Medicare is a mode of indemnity or care afforded pursuant to the laws of the United States. All of these facts were established by Blue Cross at the trial level without counterproof being offered by the Plaintiff.

As stated in *Roberts v. Davis,* Ky., 422 S.W.2d 890, 894 (1967):

> The moving party has the initial burden of showing that no genuine issue of a material fact exists,

> then the other party must refute the contentions of the moving party.

An opposing party, once the movant has established the apparent lack of factual issues (as is evidenced by the affidavits, exhibits, and memoranda in this case), must do more than state that there are factual issues or argue that a summary judgment should not be substituted for a trial. Unless he comes forward with meritorious countervailing material, a summary judgment is required by law and by equity to be granted. It is not enough that one opposing a motion for summary judgment claims that there is a genuine issue of material fact; some evidence proving the existence of an issue as to a material fact must be presented. Mere averment is insufficient.

In an attempt to avoid the exclusionary language, Plaintiff alleges oral statements were made which varied the terms of the contract. *See* Appellant's Brief at 4. It should be noted that parole evidence is inadmissible when a contract is clearly drafted; consequently, parole evidence may not be considered where such is the only "evidence" alleged to establish a triable issue of fact. As stated in 73 *American Jurisprudence 2d,* Summary Judgment, § 33 (1974):

> [W]here the only evidence relied upon to create a factual dispute in opposition to a motion for summary judgment is an oral agreement which is inoperative because of the parole evidence rule, no genuine factual dispute may be said to exist and summary judgment should be granted. . . .

*See also Booth v. Barber Transport Co.*, 256 F.2d 927 (8th Cir. 1958); *Nutrena Mills, Inc. v. Yoder*, 187 F. Supp. 415 (N.D. Iowa 1960).

Before a movant is entitled to a summary judgment, two obstacles must be overcome. A succinct statement of those elements was made in *New Amsterdam Casualty Co. v. Allen Co.*, Ky., 446 S.W.2d 278, 279-280 (1969):

> In order to be entitled to summary judgment, the moving party must establish the coexistence of two conditions; first, that beyond a doubt there is no issue existing as to any material fact; and second, that on the undisputed facts the moving party is entitled to judgment as a matter of law.

As stated previously, Plaintiff has never refuted by counter affidavit or other proof that she has available to her coverage under Medicare or that Medicare is a mode of indemnity available under the laws of the United States. Consequently, no genuine issue of material fact has been shown by Plaintiff, and the first of the obstacles has clearly been met by Blue Cross.

Second, as stated before, where an insurance contract is clear and unambiguous, the court has a duty to enforce it and give effect to it, including exclusionary provisions which are not unreasonable or forbidden by law or public policy. *See, e.g., Weaver v. National Fidelity Ins. Co., supra; Brotherhood of Railroad Trainmen v. Wilkins, supra; Pennsylvania Casualty Co. v. Elkins, supra; Interstate Business Men's Accident Ass'n v. Atkinson,* 165 Ky. 532, 177 S.W. 254 (1915). The contract at issue herein is clear and un-

ambiguous; therefore, the court has a duty to enforce it. Blue Cross, therefore, is clearly entitled to summary judgment as a matter of law.

The summary judgment proceeding in this case was not a substitute for a trial. The summary judgment was precisely the proper resolution of the matter because of the nature of the issue involved. As stated in 73 *American Jurisprudence 2d,* Summary Judgment, § 5 (1974):

> Where there is present on a motion for summary judgment a question as to the construction of a written agreement which can be reached by a consideration of the plain and unambiguous wording thereof, the question as one of law should then and there be resolved. . . .

## CONCLUSION

For the reasons stated, it is respectfully submitted that the judgment of the Daviess Circuit Court should be affirmed in its entirety.

Respectfully submitted,

JOSEPH M. DAY
RONALD L. GAFFNEY
BARNETT & ALAGIA
1700 Kentucky Home Life Building
Louisville, Kentucky 40202

*Counsel for Blue Cross*

Date: April 7, 1976